Mrs M Mather-Franks

Highbury Residential Care Home

Inspection report

Highbury
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Highbury Residential Care Home is a residential care home providing personal care to up to 8 people. The service provides support to people with learning disabilities and autism. At the time of our inspection there were 8 people using the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
People did not always receive safe care and support, and the environment was not always safe. People's needs and preferences were not always met.

Risk assessments were not always in place to assess known risks. The environment was not made safe by the provider, with areas of the building that were under renovation, fully accessible to people.

Staffing levels at night did not reflect the level of need people had, should an emergency occur. We did not see evidence the building was safe in relation to fire hazards and checks within this area.

Medicines were not always appropriately documented or managed. Cleaning fluids were not always safely stored and were a known risk to people in the service.

People were not always supported to pursue their hobbies and interests. We did not see evidence people were engaged with regularly activities of their choice. Our observations were of people mostly watching television.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff supported people to make decisions following best practice in decision-making.

Staff supported people to access health and social care services.

Right Care:
People did not receive care that was person-centred, and dignity, privacy and human rights were not always

promoted.

Some staff communicated with people in a way that was not dignified or caring. Peoples' privacy was not always respected as personal information was left accessible, and not kept securely.

Many staff had not received training in supporting people with learning disabilities and autism. Staff understood safeguarding procedures. Staff had training on how to recognise and report abuse and they knew how to apply it.

People's care plans reflected their needs and wishes and promoted their wellbeing.

Right Culture:
The ethos, values, attitudes and behaviours of the provider and manager did not always ensure people lead confident, inclusive and empowered lives.

Systems and processes were not effective in picking up and responding to any problems within the service. We saw no evidence the provider or managers knowledge within the field of learning disability and autism care and support, was up to date to ensure appropriate standards could be met.

The staff team were not always proactive in meeting people's needs, and were reacting to people's distress and boredom, rather than fostering an environment and atmosphere that would reduce the likelihood of any such distress happening.

People and those important to them, including social care professionals, were involved in planning their care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 13 March 2020).

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The inspection was prompted due to concerns received around the provider's ability to meet the standards required to safely and effectively provide support to people with learning disabilities and autism. A decision was made for us to inspect and examine those risks.

The overall rating for the service has changed from Good to Inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Highbury Residential Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, dignity and respect, person centred care and good governance, at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Highbury Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Highbury Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Highbury Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider

sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 2 people who used the service and 1 visiting relative. We spent time observing staff and people within the service. We also made calls to 4 relatives of people using the service for their feedback on the care their relatives received. We spoke with 4 care staff members, the manager, and the provider. We looked at multiple documents including care and activity plans, staff recruitment files, audits, checks and policies.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely

● Risk assessments and care plans were not followed accurately. For example, one person was cared for in bed, and their care plan stated they required checks and turns every 2 hours for their safety and skin integrity. We could not be sure these checks took place 2 hourly, as staff were regularly not recording this information within care records. We found no evidence the person had been harmed, but lack of documentation put the person at increased risk of harm.

● One person's care plan said they had a significant medical condition. The manager told us the person was on medication which was managing the medical condition successfully, however there was no information in the person's care plan about risks around the medical condition, what the signs and symptoms of a deterioration in the person's health were, and what staff should do to support the person. Failure to document these risks placed the person at increased risk of harm.

● The environment within the home was not always safe. The manager said one area of the home was out of use due to renovation. We saw the area was accessible to people and one person was using the area. Fire doors were propped open by equipment and there was clutter and trip hazards present. When we raised this with the manager they removed the person and secured the area, which caused the person distress. Suitable assessment of the environment and how changes to the environment might impact people had not been completed. This put people at increased risk of harm

● One person's care plan said they were at risk of ingesting any liquids they had available to them, including cleaning fluids. We found the laundry area within the home to be unlocked and accessible. Within the room was an unlocked cupboard with disinfectant spray inside. Further accessible cleaning fluids were found in the day service area. Access to this fluid put the person at an increased risk of harm.

● We found one person's bedroom door had an ineffective fire door. It was being held open by being tied to the wall with a dressing gown belt, and would therefore not close in the event of a fire. We could find no records of servicing for fire alarms systems or emergency lighting systems within the building. This meant people were at risk in the event of a fire.

●Medicines were not always safely stored and administered, and appropriate documentation was not always in place.

●Some people had medicines to be taken on an as and when required basis only (PRN). We found that some of these medicines were being taken routinely, without any evidence from medical professionals that they should now be routinely taken medicines. Documentation around PRN medicines was not always in place and did not always explain the reasoning behind the medicines being required. This meant that sufficient information was not available to staff to understand the medicines being administered, which placed people at increased risk of harm.

●We found out of date medicines being stored alongside current medicines. We found no evidence these medicines were being used, but they had not been disposed of or stored safely, to ensure they would not be

used. We found that some medicines which required secure refrigerated storage, were not stored securely. We found a person's medicine inside a plastic container, within a fridge, which was not secure.

These failures to effectively assess risk with people's health, the environmental risks, the ineffective management of medicines and incomplete daily records was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staffing levels were not always sufficient within the service. The manager told us one member of staff was on shift during the night. The manager told us that in the event of a fire, two people would not be evacuated, but would remain in their rooms with doors closed, which were fire safe. It was not clear if the rooms themselves were sufficiently fire safe for people to be left inside to await assistance from the fire service. Emergency planning stated both people should have staff stay with them in the event of such an emergency. Staffing numbers at night would not meet this need.
●Sufficient planning around evacuation and fire procedures in relation to suitable staffing numbers was not in place. Staff we spoke with were not aware of the emergency procedure the provider had documented should take place. This placed people at an increased risk of harm.
●During our inspection, we found staffing levels during the daytime to be sufficient to keep people safe.
● Staff were recruited safely to the service. This included ID checks, employment references, and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed, or that people were being supported to minimise the spread of infection. We found pull cords for bathroom and toilet light switches to be heavily ingrained with dirt, and had not been cleaned or replaced as required. This caused an increased infection control risk.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
Visiting procedures within the home followed government guidelines.

Learning lessons when things go wrong
● Accidents and incidents were recorded and action was taken to mitigate risks to people. Staff told us information was shared, to ensure lessons could be learnt from any mistakes made.

Systems and processes to safeguard people from the risk of abuse
● People and relatives we spoke with thought people were safe within the service. One person told us, "Yes I

feel very safe living here."

●Staff were able to explain safeguarding procedures and felt confident everything reported to managers would be followed up appropriately.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. The rating for this key question has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff were not always fully trained to support the people within the home. Highbury Residential Care Home provides care and support to people with learning disabilities and autism. Staff working with people who have learning disabilities and autism should be given specific training in this area. Only 2 staff had received this type of training. The manager told us staff were booked on to upcoming training. Other basic training courses had been undertaken.
- Staff told us they received an induction when joining the service which included reading care plans and completing basic training courses. For staff without previous experience, the care certificate was completed. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

Adapting service, design, decoration to meet people's needs

- The communal areas within the service were dated and tired. Paintwork was old and chipped in places, and old pictures and ornaments decorated the walls. There was no evidence people had been involved in the design or decoration of any of the communal areas within the home.
- The lower floor of the building was assigned as a 'day centre' for the people living at the service, although it was a part of the same building, accessible, and part of their home. The manager told us this area was under renovation.
- Some people's rooms had undergone decoration, and their choices around how their rooms looked were respected. Rooms were personalised to people's needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- An assessment of people's needs was completed before they moved into the service. Most people's care plans identified what their needs were, and what their preferences and choices were.
- People's needs in relation to equality and diversity were considered and documented within their care plans.

Supporting people to eat and drink enough to maintain a balanced diet;

- People were encouraged to maintain a healthy diet. People told us they enjoyed the food on offer, and if they didn't like something, they could ask for something else. There was a pictorial menu on display, although it had not been updated on the day of inspection.
- Care plans documented any food and fluid likes, dislikes, allergies and requirements.

Supporting people to live healthier lives, access healthcare services and support Staff working with other agencies to provide consistent, effective, timely care

●Relatives we spoke with were confident people's medical and health needs were managed well. One relative told us, "They inform me about [name] medical needs. The staff understand [name's] needs."

● Information identifying health and social care professionals involved in people's care, and their contact details were contained within people's records. Staff alerted health and social care professionals where they had concerns about people's health and well-being. Action was taken to make sure medical attention was sought when required.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

●People's capacity to make informed decisions was considered. The service had worked alongside other professionals in ensuring appropriate authorisations were applied for when depriving a person of their liberty.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

● Interactions we observed between staff and people were mixed. Some interactions were positive, although at times, staff did not always give people the time they required, or communication they needed to support their wellbeing. For example, one person was asking a staff member about food. The staff member then communicated with them in a firm and loud manner, telling them to stop asking about food as they had just had some tea. This was not a kind or caring interaction with the person.

●One person was eating lunch that was just served to them. In front of other people and staff, the staff member in a firm tone told them to stop eating, as they needed to have their medicines first. They repeated this loudly at the person several times in order to get them to stop eating. This was not a dignified or respectful interaction with the person, who appeared agitated.

●One person was telling a staff member they had plans to go out and buy an item from the shop, the staff member repeatedly told them they were not going out to the shop to buy this item. Another staff member corrected the first staff member, and said the person's plans were correct, and going ahead. The staff member did not apologise for being incorrect and told the person they didn't need to keep talking about it. These interactions meant people were not always treated in a kind and dignified manner by staff.

●People's information was not always stored securely. We found folders containing information around people's daily routines and activity were left on the table in the communal lounge, accessible to everyone within the home. Staff told us they were kept there for easy access. We did not see anyone inappropriately access another person's private information, but this unsecure storage increased the risk around people's privacy and dignity not being respected.

These interactions with people living at the service were not always mindful of people's dignity and respect, and this was a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff were well informed about the people they were supporting, and told us they enjoyed working with people, however the culture within the service was not always proactive. Staff appeared to wait and react to people communicating distress or boredom, rather than have a planned approach to support people in their interests through the day.

● Staff knew the people they were supporting well. One relative told us, "The staff know [name] very well. They are very loving and nurturing." One person told us, "I like all the staff here. They are all nice to me. I like living here."

●People felt their privacy was respected. One person confirmed to us staff respected their personal space and privacy, and knocked on their door before entering the room.

Supporting people to express their views and be involved in making decisions about their care

● People and their relatives told us they were involved in their own care and were able to make decisions when possible. One relative told us, "The staff know [name] well, and how to get the best from them. There is a team approach, home and family working together."

●Care planning documents explained people's preferences and needs, and how they could be involved in their own care and decision making where possible.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to Requires improvement: This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were not regularly engaged in meaningful hobbies and interests. Activity records we viewed showed the majority of time was spent watching TV, listening to music, or was listed as 'Day service'. The home had an internal 'Day service' area which was under renovation. We observed some people were offered a game of dominoes, but many people spent most of their day seated watching television, with minimal engagement from staff.

●We observed some people throughout the day express distressed behaviours and vocalisations. Staff were reactive and not proactive in their approach to managing this. Some people were offered walks, but only if they were able to wait their turn, until someone else got back first. People's agitation and distress appeared to be out of boredom and lack of stimulation and meaningful activity.

●The manager and staff told us other activities did take place, but clear records did not always document what people had done, why they had done it, or whether it was an activity of their choice that was of interest to them.

This care and treatment did not always reflect people's needs and preferences, and was a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care plans did contain personalised information about people, some of their personal history, and their preferences.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

●Information was made available to people in a range of formats, including pictorial menus and pictorial complaints procedures.

Improving care quality in response to complaints or concerns

● A complaints policy and procedure was in place, and people and their relatives knew how to use it. At the time of inspection, no complaints had been made.

End of life care and support

●Nobody living at the service required end of life care at the time of inspection. End of life care information was completed for people who wished to, which included future planning for wishes and preferences around the person's end of life care.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate: This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There were widespread failures by the provider to maintain a safe and effective service for the people using the service, as detailed in the key questions above, and several breaches of regulation had occurred.
- Systems and processes were either not in place or not effective to monitor quality, and ensure the building and environment was safe for people to use. Medicines were not always administered safely, fire safety procedures were not always sufficient, and risk assessments were not always created or followed to manage and document known areas of risk.
- The provider and management had not maintained a culture within the service that was proactive in meeting the needs of people with a learning disability and autism, and the provider and manager could not evidence their knowledge within this field was up to date to ensure appropriate standards could be met.
- We looked at the monthly audits and checks that were taking place, and found they were not sufficient in picking up on the issues within the service.

These failures to assess, monitor and mitigate risks within the service, and failure to maintain a positive culture and ensure appropriate standards were met, was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff members felt well supported by the manager. One staff member said, "I get on really well with the manager, can speak with her, she is very open and honest. If I had a problem I could go to her and she would listen."
- The manager had a good relationship with people and staff, and understood the skills of the staff team.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The manager was aware of the duty of candour, and that if mistakes were made, they had a duty to be open and honest and take any necessary action.
- The manager understood information sharing requirements and knew that when concerns were identified, notifications should be sent to the CQC as required by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

●People and relatives of people were engaged in the service. One relative we spoke with said, "I feel very well informed, I speak to the manager most weeks."
●Feedback was enabled through questionnaires sent to relatives, the results of which were largely positive. People's own views were also sought in resident meetings, where a variety of topics were discussed.

Working in partnership with others
● Contact with health professionals was made promptly to ensure joined up care was effective and met people's needs.
● The manager and provider were open and receptive to feedback during our inspection.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Failure to evidence that people were regularly engaged with activities of their choice. Staff reacting to peoples distress and boredom, rather than being proactive and providing an engaging atmosphere.

The enforcement action we took:

WN

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Not all staff were interacting with people in a dignified and kind manner.

The enforcement action we took:

WN

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failures to risk assess, provide a safe environment, manage medicines, provide safe staffing at night, provide evidence of fire and safety checks.

The enforcement action we took:

WN

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Widespread failures across the service and multiple breaches of regulation. Failure to provide an environment and culture suitable for people with learning disabilities and autism.

The enforcement action we took:

WN